Wisconsin Medicaid Hospital Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING
WISCONSIN MEDICAID AND BADGERCARE
PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Telephone: 800-947-9627
608-221-9883
dhfs.wisconsin.gov/medicaid
dhfs.wisconsin.gov/badgercare

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746, or indicate your interest in electronic billing by completing the form in your certification materials.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Mark B. Moody
Administrator

MBM:mhy
MA11065/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to Wisconsin Medicaid:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Certification Requirements
3.	Terms of Reimbursement
4.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance** This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

WISCONSIN MEDICAID HOSPITAL CERTIFICATION CRITERIA

Hospitals participating in the peer review organization (PRO) review program must meet the requirements of 42 CFR 456.101 and any additional requirements established under state contract with the PRO. In compliance with the Code of Federal Regulations at 42 CFR 482.1(5), hospitals receiving payment under Medicaid must meet the requirements of conditions of participation for Medicare.

Medicaid must verify approval under ch. HFS 124, and Joint Commission of Healthcare Organization (JCAHO) accreditation of Medicare certification before a provider number may be issued. If the hospital is JCAHO accredited, the hospital must submit proof of accreditation the hospital is also requested to send a copy of the hospital Medicare certification notice with the hospital application, if available.

If the hospital is not approved under ch. HFS 124, or certified by Medicaid, the hospital must apply with a separate application for certification. Information regarding Medicaid certification approval and Medicare certification may be obtained from the Bureau of Quality Assurance, P.O. Box 2969, Madison, WI 53701-2969.

Do not hold the hospital application until you receive the hospital Medicare certification If the hospital has not yet had the hospital Medicare survey or received the hospital Medicare certification notice, Wisconsin Medicaid will hold the hospital application on file until a copy of the hospital Medicare certification approval is received by the Wisconsin Medicaid program. Facilitate this process by sending a copy of the hospital Medicare certification notice to Wisconsin Medicaid as soon as you receive it. This notice must be received by Wisconsin Medicaid within 30 days of the letter's date for the earliest possible Medicaid effective date to be assigned.

Critical Access Hospitals

A Critical Access Hospital (CAH) must meet the requirements specified under 42 CFR 485, Subpart F, be designated as a CAH by the Health Care Financing Administrative (HCFA), meet the requirements specified in HFS 124.40 Wis. Adm. Code, and be designated as a CAH by the Department of Health and Family Services.

Psychiatric Hospitals (IMD Hospitals)

Federal regulations at 42 CFR 436.1009 provide the following definition of an IMD:

> "Institution of mental diseases means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental disease whether or not it is licensed as such. An institution for the mental retarded is not an institution for mental diseases."

HFS 105.21 Hospital IMD. Section HFS 105.21, Wis. Adm. Code, contains the specific criteria for certification of psychiatric hospitals. (1) REQUIREMENTS. For Medicaid certification, a hospital which is an institution for mental disease (IMD) shall:

(a) Meet the requirements of s. HFS 105.07, and;

1. Maintain clinical records on all patients, including records sufficient to permit determination of the degree and intensity of treatment furnished to Medicaid recipients, as specified in 42 CFR 482.61; and

2. Maintain adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in dischange planning, as specified in 42 CFR 482.62;

(b) Have a utilization review plan that meets the requirements of 42 CFR 405.1035, 405.1037 and 405.1038;

(c) If participating in the PRO review program, meet the requirements of that program any other requirements established under the state contract with PROs;

(d) If providing outpatient psychotherapy, comply with s. HFS 105.22;

(e) If providing outpatient alcohol and other drug abuse services, comply with s. HFS 105.23; and

(f) If providing day treatment services, comply with s. HFS 105.24.

(2) WAIVERS AND VARIANCES. The Department shall consider applications for waivers or variances of the requirements in sub. (1) if the requirements and procedures stated in s. HFS 106.11 are followed.

Diseases listed as mental disorders in the International Classification of Disease including patients being treated for chemical dependency, but excluding mental retardation, senility and organic brain syndrome.

HFS 105.075 Rehabilitation Hospitals. For Medicaid certification, a rehabilitation hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. HFS 124, including the requirements for rehabilitation services under s. HFS 124.21, shall meet conditions of participation for Medicare and shall have utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the Department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a rehabilitation hospital under this section.

General Hospitals

Section HFS 105.07, Wisconsin Administrative Code, states the criteria for certification of general hospitals.

Hospitals must be approved under s. 50.35, Stats., and ch. HFS 124, must have a utilization review must either have a Medicare provider agreement or be accredited by the JCAHO, and plan that meets the requirements of 42 CFR 405.1035.

Hospitals must meet the requirements specified in s. HFS 105.22, Wis. Adm. Code, if providing outpatient psychotherapy and the requirements specified in HFS 105.23, Wis. Adm. Code, if providing outpatient alcohol and other drug abuse (AODA) services. Hospitals providing outpatient mental health or AODA day treatment services must obtain separate certification under either s. HFS 105.24 or s. HFS 105.25.

Wisconsin Medicaid Hospital Rate Setting

Upon certification, a hospital must contact the Division of Health Care Financing to establish a Medicaid hospital-specific base rate for inpatient hospital services and an outpatient hospital rate per visit. For more information about Medicaid hospital rates, contact:

Hospitals, Physicians, and Clinics Section
Division of Health Care Financing
Department of Health and Family Services
1 W. Wilson Street, Room 350, P.O. Box 309
Madison, WI 53701-0309
Phone: (608) 266-3901
Fax: (608) 266-1096

Interim Payment

Attach a copy of the Interim Payment Rate Adjustment letter sent by Medicare as part of the Medicare certification process. Send a copy to the Bureau of Quality Assurance immediately upon receipt from HCFA/Medicare.

Hospitals may be certified as CAHs general hospitals, or special hospitals pursuant to s. 50.33 Wis. Stats. Hospitals will be designated according to the determination of the Bureau of Quality Assurance. If the hospital meets the federal definition of an IMD, the hospital must be designated a psychiatric hospital.

Professional Services Excluded from DRG Payments

Certain professional and other services are excluded from the diagnosis related group (DRG) payment system. Professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded, when the professionals are functioning in the capacity of:

- Physicians
- Psychiatrists
- Psychologists
- Physician Assistants
- Nurse Mid-wives
- Chiropractors
- Dentists
- Optometrists
- Hearing Aid Dealers
- Audiologists
- Podiatrists
- Independent Nurse Practitioners
- Anesthesia Assistants
- Certified Registered Nurse Anesthetists
- Pharmacy, for take-home drugs on the date of durable medical equipment and supplies for non-hospital use
- Specialized Medical Vehicle Transportation
- Air, Water, and Land Ambulance

Provider Types: 61, 62, 64

Effective Date: February 1, 1991
Revised Date: December 2001

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BORDER STATUS HOSPITALS
TERMS OF PROVIDER REIMBURSEMENT

Inpatient and outpatient hospital services, approved by the Wisconsin Medicaid Program shall be paid in accordance with the Wisconsin Inpatient and Outpatient State Plan for Hospital Reimbursement, effective July 1, 1999, or as may be amended.

The Department shall adjust payments made to providers to reflect the amounts of any allowable copayments which providers are required to collect pursuant to Chapter 49, Wis. Stats, currently in effect or as amended.

Payment made to border status hospitals are not subject to administrative adjustment under Section VI of the State Plan.

Effective Date: July 1, 1986
Renewed: September 2000

Jim Doyle
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State of Wisconsin

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HOSPITAL
TERMS OF PROVIDER REIMBURSEMENT

Interim payment and final hospital reimbursement rates for services rendered commencing with the effective date of the provider agreement shall be determined by the Department of Health and Family Services pursuant to the Inpatient and Outpatient Hospital State Plan for Title XIX Hospital Reimbursement, effective July 1, 1999, or as may be amended.

Interim hospital payments may be adjusted during the term of the provider agreement to more closely approximate the final reimbursement rates.

Providers are required to bill their usual and customary charges for services provided, that charge being the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, usual and customary charge means the median of the individual provider's charge for the service when provided to non-Medicaid patients.

The Department shall adjust payments made to providers to reflect the amounts of any allowable copayments which providers are required to collect pursuant to Chapter 49, Wis. Stats.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wis. Stats.

In accordance with Federal regulations 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting payment rates for services.

WISCONSIN MEDICAID

HOSPITAL APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.
3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
HOSPITAL APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:
☐ Hospital.
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. This is the address used for mailing Medicaid information. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person, Telephone Number, and Fax Number — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial)			
Name — Group or Contact Person			
Address — Physical Work			
City	State	Zip Code	County
Date of Birth — Individual	SSN		Name — Medicaid Contact Person
Telephone Number	Fax Number		
Current and/or Previous State Medicaid Provider Number ☐ Wisconsin ☐ Other			
Medicare Part A Number			Effective Date
Medicare Part B Number			Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic / Group Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	County	State	Zip Code

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Hospital — Number of Beds: Acute___ Psych___ AODA___
  - ☐ General.
  - ☐ Institution for Mental Disease (IMD).
  - ☐ Critical Access.
  - ☐ Long-term Care.

SECTION V — APPLICANT'S TYPE OF BUSINESS

Applicant's type of business:

- ☐ Individual.
- ☐ Sole Proprietor:
  County and state where registered _____.
- ☐ Corporation for Nonprofit.
  Check type: ☐ Limited Liability ☐ Publicly owned ☐ Privately owned ☐ Municipality
- ☐ Corporation for Profit.
  State of registration _____

  Names of corporate officers _____

  _____
- ☐ Partnership.
  State of registration _____.

  Names of all partners and SSNs (use additional sheet if needed):

  Name _____ SSN _____

  Name _____ SSN _____
- ☐ Other, specify _____.

Definitions for Sections VI-VIII

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VI — TERMINATION / CONVICTION / SANCTION INFORMATION

During the preceding five years, has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION VII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy.

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section VIII.

Name			
Medical Provider Number(s)	SSN / EIN		
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION VIII — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity			
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	
SSN or IRS Tax Number	Provider Number, if applicable		

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DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(For Hospitals participating in the Wisconsin Medicaid Program)

The State of Wisconsin, Department of Health and Family Services, hereby refers to as the Department enters into an agreement with:

_____,
(Provider's Name and Number)

a Provider of health services, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, relating to Title XIX of the Social Security Act and State law pertinent to Wisconsin's Medicaid Program, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, as are now in effect or as may later be amended. If the Provider employs ten or more employees and receives $10,000 or more annually in Medicaid reimbursement, the provider further agrees to comply with the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Provider Reimbursement," as are now in effect or as may later be amended.

3. This contract shall expire on the last day immediately following the effective date. Renewal shall be governed by HFS 105.02(8), Wis. Adm. Code, as amended.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

Name of Provider

Address

By: _____
Authorized Signature

Title: _____

Date: _____

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND
FAMILY SERVICES

BY: _____

DATE: _____

THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

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Name of Provider

Address

By: _____
Authorized Signature

Title: _____

Date: _____

(For Department Use Only)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND
FAMILY SERVICES

BY: _____

DATE: _____

THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE

WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: *dhfs.wisconsin.gov/medicaid9/pes/pes.htm* or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.